

**1915(i) State Plan Home and Community-Based Services  
 Administration and Operation**

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below. State: MONTANA

**1. Services.** *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Consultative Clinical and Therapeutic Services; Supplemental Supportive Services; Education and Support Services; Family Support Specialist; High Fidelity Wraparound Facilitation; In-Home Therapy (by a licensed mental health professional); Non-Medical Transportation; Peer to Peer Services; Respite; Specialized Evaluation Services; Co-Occurring Services and Crisis Intervention Services.

**2. Statewideness.** *(Select one):*

<input checked="" type="radio"/>	The State implements the 1915(i) State plan HCBS benefit statewide, per §1902(a)(1) of the Act.
<input type="radio"/>	The State implements this benefit without regard to the statewideness requirements in §1902(a)(1) of the Act. State plan HCBS will only be available to individuals who reside in the following geographic areas or political subdivisions of the State. <i>(Specify the areas to which this option applies):</i>

**3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** *(Select one):*

<input checked="" type="radio"/>	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program <i>(select one)</i> :	
<input type="radio"/>	The Medical Assistance Unit <i>(name of unit)</i> :	
<input checked="" type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit <i>(name of division/unit)</i> <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i>	Developmental Services Division Children’s Mental Health Bureau
<input type="radio"/>	The State plan HCBS benefit is operated by <i>(name of agency)</i>	
a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

**4. Distribution of State plan HCBS Operational and Administrative Functions.**

- *(By checking this box the State assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

*(Check all agencies and/or entities that perform each function):*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 State plan HCBS enrollment managed against approved limits, if any	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Eligibility evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Review of participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Prior authorization of State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9 Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):*

MMIS contractor with the Montana Department of Public Health and Human Services, manages MMIS, pays claims, and executes the Medicaid provider agreement

(By checking the following boxes the State assures that):

5. ■ **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
- related by blood or marriage to the individual, or any paid caregiver of the individual
  - financially responsible for the individual
  - empowered to make financial or health-related decisions on behalf of the individual
  - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

The State assures the independence of persons performing evaluations, assessments, and plans of care (services plans). The evaluations, assessments and the initial and annual plans of care (service plans) will be completed by the Department's Regional Managers.

6. ■ **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
7. ■ **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.
8. ■ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

**Number Served**

**1. Projected Number of Unduplicated Individuals To Be Served Annually.**

*(Specify for year one. Years 2-5 optional):*

Annual Period	From	To	Projected Number of Participants
Year 1	1/1/13	12/31/13	56
Year 2			
Year 3			
Year 4			
Year 5			

- 2.  Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

**Financial Eligibility**

- 1.  Income Limits\*.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in an eligibility group covered under the State’s Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

- 2. Medically Needy.** *(Select one):*

<input type="radio"/>	The State does not provide State plan HCBS to the medically needy.
<input checked="" type="radio"/>	The State provides State plan HCBS to the medically needy <i>(select one):</i>
<input type="radio"/>	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
<input checked="" type="radio"/>	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

**3. Target Group(s)**

**X Target Group(s).** The State elects to target this 1915(i) State plan HCBS benefit to a specific population. With this election, the State will operate this program for a period of 5 years. At least 180 days prior to the end of this 5 year period, the State may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C). *(Specify target group(s)):*

- Youth ages 5 through 17, unless youth is still in secondary school, and then may consent to 1915(i) HCBS program until age 20; and
- Serious Emotional Disturbance criteria met.

**Needs-Based Evaluation/Reevaluation**

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*select one*):

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="radio"/>	By Other ( <i>specify State agency or entity with contract with the State Medicaid agency</i> ): Montana Department of Public Health and Human Services (Department) Regional Managers.

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. (*Specify qualifications*):

Regional Managers' qualifications include Bachelor's degree in related human service field and two years of experience in health, behavioral health, or human services; including one year experience with children's mental health treatment system.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The process for evaluation whether youth meet the needs-based State plan HCBS eligibility criteria includes the following:

- (1) The youth is referred to the Regional Manager by PRTF facilities, local hospitals, other child serving agencies, parents and/or advocates, schools, physicians, and any source for potentially needing the 1915(i) HCBS services.
- (2) The Regional Manager confirms Medicaid eligibility.
- (3) The Regional Manager completes the needs-based criteria review (may be a paper review).
- (4) The Regional Manager completes needs-based criteria review and may contact other entities including but not limited to the youth's physician, licensed mental health professional, local CHMB staff; schools, physicians, families and all other sources to determine if the youth meets the "needs-based" criteria outlined in Number 4, Needs-based HCBS Eligibility Criteria.
- (5) If the youth meets the "needs-based" criteria, the Regional Manager contacts the youth and family by phone or in person and asks if they are interested in 1915(i) services delivered via a high fidelity wraparound facilitation process. If yes, the Regional Manager schedules a face-to-face assessment.
- (6) The Regional Manager completes the face-to-face assessment (which is not a clinical assessment) to explore needs of the youth and family. If/when the Regional Manager identifies need for at least one 1915(i) services the Regional Manager asks youth, family/legal guardian to sign release forms, and consent forms.
- (7) The Regional Manager develops the initial and annual Service Plan.

TN 13-036 Effective: 7/1/13      Approved: 09/20/13      Supersedes: TN 12-026

- (8) The Regional Manager completes the enrollment form for all youth enrolling in the 1915(i) HCBS state plan program.
- (9) The Regional Manager sends copies of all plans of care and all enrollment forms to the Program Manager.
- (10) The Regional Manager refers the youth and family to the High Fidelity Wraparound Facilitator chosen by the youth/family.
- (11) If the youth does not meet the “needs-based” criteria, a letter of denial is sent by the Regional Manager in accordance with the section regarding **Fair Hearings and Appeals**. The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
- (12) The reevaluation process follows the evaluation process. The evaluation and reevaluation process uses the same needs-based criteria.

4. ■ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual’s support needs, and may include other risk factors: *(Specify the needs-based criteria)*

- (1) Resources available in the community do not meet the treatment needs of the youth;

*AS DOCUMENTED BY AT LEAST TWO OF THE FOLLOWING RISK FACTORS (a–d):*

- (a) *The youth has had at least one admission to a PRTF (facility) in the past 12 months.*
- (b) *The youth has had at least one admission to a local, community, in-patient hospital related to behavioral health needs, not physical health needs, in the past 12 months.*
- (c) *The youth has had at least one admission to a therapeutic group home in the past 12 months.*
- (d) *In lieu of 1915(i) services, the youth is at risk of placement in a PRTF per assessment of referral information.*

**OR AT LEAST ONE OF THE ABOVE (a-d) AND AT LEAST ONE OF THE FOLLOWING:**

- (e) *The youth is receiving three or more of the following types of outpatient services in the community setting and is not making progress:*

- *Outpatient therapy with or without medication management;*
- *Comprehensive School and Community Treatment;*
- *Day treatment OR partial hospitalization;*
- *Therapeutic family care OR therapeutic foster care;*
- *Respite.*

And (2) The services can reasonably be expected to improve the youth's condition or prevent further regression.

5. ■ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional

level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

**Needs-Based/Level of Care (LOC) Criteria -**

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
<p>1. Resources available in the community do not meet the treatment needs of the youth; AS DOCUMENTED BY AT LEAST TWO OF THE FOLLOWING RISK FACTORS (a-d)</p> <p><i>a) The youth has had at least one admission to a PRTF (facility) in the past 12 months.</i></p> <p><i>b) The youth has had at least one admission to a local, community, in-patient hospital related to behavioral health needs, not physical health needs, in the past 12 months.</i></p> <p><i>c) The youth has had at least one admission to a therapeutic group home in the past 12 months.</i></p> <p><i>d) In lieu of 1915(i) services, the youth is at risk of placement in a PRTF per assessment of referral information.</i></p> <p><b>OR AT LEAST ONE OF THE ABOVE (a-d) AND AT LEAST ONE OF THE FOLLOWING</b></p> <p><i>e) The youth is receiving three or more of the following types of outpatient services in the community setting and is not making progress:</i></p> <ul style="list-style-type: none"> <li><i>-Outpatient therapy with or without medication management;</i></li> <li><i>-Comprehensive School and Community Treatment;</i></li> <li><i>-Day treatment OR partial hospitalization;</i></li> <li><i>-Therapeutic family care OR therapeutic foster care; -Respite.</i></li> </ul> <p>TN: 03-036 effective: 7/1/13</p>			<p>Hospital Admission criteria require a covered DSM-IV diagnosis as the primary diagnosis and a determination that the youth has a serious emotional disturbance. In addition, all of the following must be met:</p> <ol style="list-style-type: none"> <li>1. Symptoms or functional impairments of the youth's emotional disturbance are of a severe and persistent nature and require 24-hour treatment under the direction of a physician;</li> <li>2. Less restrictive services are documented to be insufficient to meet the youth's severe and persistent clinical and treatment needs. The prognosis for treatment at this level of care can reasonably be expected to improve the youth's condition or prevent further regression based upon the physician's evaluation;</li> <li>3. The treatment plan includes the active participation of the parent(s) or legal custodian and all active pre-admission caregivers.</li> </ol> <p>Approved: 09/20/13 Supersedes: TN 12-026</p>

State: MONTANA

And (2) The services can reasonably be expected to improve the youth's condition or prevent further regression.

Supplement to Attachment 3.1-I  
§1915(i) HCBS State Plan Services for High  
Needs Youth with SED  
Page 8

\*Long Term Care/Chronic Care Hospital

(By checking the following boxes the State assures that):

6. ■ **Reevaluation Schedule.** Needs-based eligibility reevaluations are conducted at least every twelve months.
7. ■ **Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).
8. ■ **Residence in home or community.** The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:
  - (i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or
  - (ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

All enrolled youth will be residing in a family home setting (no group homes; no facility-based settings). When the youth resides in a licensed foster home and is seeking enrollment in the 1915(i) HCBS state plan program, the Program Manager will ensure there is no duplication with Medicaid and the obligation and payment for services to this youth as part of Title IV-E; the Regional Manager will be apprised of which 1915(i) services may be authorized. These youth will be tracked by the Program Manager and the appropriate staff in the Child and Family Services Division will be informed of the plan of care and 1915(i) services authorized.



## Person-Centered Planning & Service Delivery

(By checking the following boxes the State assures that):

- There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:
    - An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
    - Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
    - An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
    - An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
    - If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
    - A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.
1. ■ Based on the independent assessment, the individualized plan of care:
    - Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
    - Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
    - Prevents the provision of unnecessary or inappropriate care;
    - Identifies the State plan HCBS that the individual is assessed to need;
    - Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
    - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
    - Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.
  2. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.**  
There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

The Regional Manager will complete the face-to-face assessment of youth who've been evaluated and meet the needs-based State plan HCBS eligibility criteria. All

TN 13-036 Effective: 7/1/13 Approved: 09/20/13 Supersedes: TN 12-026

pertinent information gathered as part of the needs-based evaluation will be provided to the Regional Manager prior to the face-to-face assessment. Regional Managers' qualifications include Bachelor's degree in related human service field and two years of experience in health, behavioral health, or human services; including one year experience with children's mental health treatment system.

- 3. **Responsibility for Plan of Care Development.** There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

The Regional Manager is responsible for the development of the initial and annual individualized, person-centered Service Plan using information gathered during the need-based eligibility process and the face-to-face assessment. Subsequent revisions during the intervening 12 months are the responsibility of the Regional Managers. Regional Managers' qualifications include Bachelor's degree in related human service field and two years of experience in health, behavioral health, or human services; including one year experience with children's mental health treatment system.

- 4. **Supporting the Participant in Plan of Care Development.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The Regional Manager will complete the initial and annual Service Plan for the youth based on the information gathered from the needs-based criteria review and the face-to-face assessment. The Regional Manager will provide the youth/family information about the person-centered planning process, their opportunity to select who participates in the planning process and the services and available providers.

- 5. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*

The Regional Manager will provide a list of High Fidelity Wraparound Facilitators for the youth/family to choose. Additionally, the High Fidelity Wraparound Facilitators will maintain a listing of qualified providers of 1915(i) services and youth/families will choose qualified providers from this listing. The list maintenance will be the responsibility of the Children's Mental Health Bureau; information will be updated as new providers are available. The Regional Manager positions throughout the state will have ongoing responsibility to ensure there are sufficient providers; that the lists are accurate; meet with potential providers to build capacity; and involve the CMHB management staff as needed.

- 6. **Process for Making Plan of Care Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

The Regional Manager will engage the youth and families in the development of the initial and annual Service Plan. The appropriate signatures will be obtained by the Regional Manager and copies of the plans of care will be on file in the Regional Managers locations

where they have oversight. Regional Managers approve or deny the plans of care. The Regional Managers will also complete an enrollment form for every youth enrolled in the 1915(i) HCBS state plan program with copies of the enrollment forms and plans of care going to the Program Manager in the CMHB for general program oversight.

7. **Maintenance of Plan of Care Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following (*check each that applies*):

<input checked="" type="checkbox"/>	Medicaid agency	<input type="checkbox"/>	Operating agency	<input type="checkbox"/>	Case manager
<input type="checkbox"/>	Other ( <i>specify</i> ):				

## Services

**1. State plan HCBS.** (Complete the following table for each service. Copy table as needed):

<b>Service Specifications</b> (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):			
Service Title:	Consultative Clinical and Therapeutic Services		
Service Definition (Scope):			
<p>Consultative Clinical and Therapeutic Services will ensure enrolled youth receive access to psychiatric consultation by providing the youth’s physician or mid-level practitioner consultations with psychiatrists by means other than face to face (e.g. telephonic; web-based; Skype; telemedicine). This service is specifically designed to provide treating physicians and mid-level practitioners with psychiatric expertise and opportunity for consultation in the areas of diagnosis, treatment, behavioral and medication management. If the youth is able to have a face-to-face visit with the psychiatrist, this visit is a covered service under state plan Medicaid (not a 1915(i) service). Face-to-face visits are preferred but not always possible; hence the 1915(i) service will ensure the youth receives access to psychiatric treatment. State plan Medicaid does not pay for consultation services. The individualized plan of care must identify a need for this service.</p>			
Additional needs-based criteria for receiving the service, if applicable (specify):			
Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):			
■	Categorically needy (specify limits):		
	State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.		
■	Medically needy (specify limits):		
	State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.		
<b>Provider Qualifications</b> (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Psychiatrist	Licensed by the State of Montana.		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
Physician or Mid-Level Practitioner	Licensed by the State of Montana.		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
<b>Verification of Provider Qualifications</b> (For each provider type listed above. Copy rows as needed):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):		Frequency of Verification (Specify):
Psychiatrist or Physician	MMIS Contractor, Montana Department of Public Health and Human Services.		Upon enrollment and annually thereafter.
TN: 13-036	Effective: 7/1/13	Approved: 09/20/13	Supersedes: 12-026

State: MONTANA	Supplement to Attachment 3.1-I §1915(i) HCBS State Plan Services for High Needs Youth with SED	Page 13
Mid-Level Practitioner	MMIS Contractor, Montana Department of Public Health and Human Services.	Upon enrollment and annually thereafter.
<b>Service Delivery Method.</b> (Check each that applies):		
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/> Provider managed

<b>Service Specifications</b> (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):			
Service Title:	Supplemental Supportive Services		
Service Definition (Scope):			
Use of Supplemental Supportive Services must be tied to a need or goal specified in the written individualized plan of care and be related to one or more of the following outcomes: success in school, maintaining the youth in the home; development and maintenance of healthy relationships, prevention of or reduction in adverse outcomes (e.g. arrest, delinquency, victimization and exploitations) and becoming or maintaining a stable and productive member of the community. Supplemental Supportive Services are available to purchase services/goods not generally covered by Medicaid or other sources. These services enable youth to access to supports designed to improve and maintain opportunities for membership in the community, socialization and enrichment (summer camp; extra-curricular activity or sports activity not covered by the school; purchase of an electronic device such as an I-Pod with soothing music; health club punch card to encourage a healthier life-style and promote self-esteem). Experimental or prohibited treatments are excluded.			
Additional needs-based criteria for receiving the service, if applicable (specify):			
Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):			
<input checked="" type="checkbox"/>	Categorically needy (specify limits):		
	Supplemental Supportive Services are limited to \$1000 per year of youth's enrollment and cannot be used for such items including but not limited to monthly rent or mortgage, food, regular utility charges, household appliances, automobile purchases or repairs, and insurance. State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.		
<input checked="" type="checkbox"/>	Medically needy (specify limits):		
	Supplemental Supportive Services are limited to \$1000 per year of youth's enrollment and cannot be used for such items including but not limited to monthly rent or mortgage, food, regular utility charges, household appliances, automobile purchases or repairs, and insurance. State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.		
<b>Provider Qualifications</b> (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Agency with fiduciary capacity TN 13-036	None  Effective: 7/1/13	None  Approved: 09/20/13	Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.  Supersedes: 12-026

<b>Verification of Provider Qualifications</b> (For each provider type listed above. Copy rows as needed):		
Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Agency	MMIS Contractor, Montana Department of Public Health and Human Services.	Upon enrollment.
<b>Service Delivery Method.</b> (Check each that applies):		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed	

<b>Service Specifications</b> (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):	
Service Title:	Education and Support Services
Service Definition (Scope):	
Education and Support Services provide information about the youth’s diagnostic characteristics, developmental needs, and treatment regimens (including but not limited to medication and behavioral management). This service has been designed to provide support for youth with serious emotional disturbance through skill-building in coping skills, self-advocacy, and individualization of response to the youth’s needs. The provider of Education and Support Services will provide materials, space and hand-outs. The individualized plan of care must identify a need for this service.	
Additional needs-based criteria for receiving the service, if applicable (specify):	
Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):	
<input checked="" type="checkbox"/>	Categorically needy (specify limits): State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. The State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.
<input checked="" type="checkbox"/>	Medically needy (specify limits): State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. The State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

<b>Provider Qualifications</b> (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Agency with the capacity to provide trainings TN: 13-036	None  Effective: 7/1/13	None  Approved: 09/20/13	Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.  Supersedes: TN 12-026

State: MONTANA  specific to the needs of youth with serious emotional disturbance with curriculum approved by the Department (CMHB).			Supplement to Attachment 3.1-I §1915(i) HCBS State Plan Services for High Needs Youth with SED  <hr/> Page 15
--	--	--	--

**Verification of Provider Qualifications** (For each provider type listed above. Copy rows as needed):

Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Agency	MMIS Contractor, Montana Department of Public Health and Human Services.	Upon enrollment.

**Service Delivery Method.** (Check each that applies):

<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
---	--

**Service Specifications** (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):

Service Title: Family Support Specialist

Service Definition (Scope):

Family Support Specialist works under the guidance of the home-based therapist and provides support and interventions to parents and youth. Tasks may include but are not limited to: assisting the therapist in family therapy by helping the parent/youth communicate their needs and concerns; providing feedback to the therapist about observable family dynamics; helping the family/youth implement changes discussed in the family therapy and/or parenting classes; providing information to the parents regarding their youth's mental illness; coaching, supporting and encouraging new parenting techniques; serving as a member of a crisis intervention team. The individualized plan of care must identify a need for this service.

Additional needs-based criteria for receiving the service, if applicable (specify):

Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):

<input checked="" type="checkbox"/>	Categorically needy (specify limits):
	A Family Support Specialist who is also a licensed mental health professional cannot provide any other state plan services for the youth.  State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.
<input checked="" type="checkbox"/>	Medically needy (specify limits):

State: MONTANA

Supplement to Attachment 3.1-I  
§1915(i) HCBS State Plan Services for High Needs Youth with SED  
Page 16

A Family Support Specialist who is also a licensed mental health professional cannot provide any other state plan services for the youth.

State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.

**Provider Qualifications** (For each type of provider. Copy rows as needed):

Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Agency			Provider with fiduciary and managerial capacity; must ensure the Family Support Specialist has a Bachelor's degree in the Human Service field OR a minimum of three years direct experience working with youth with serious emotional disturbance and their families. The agency must ensure the Family Support Specialist receives clinical supervision. Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
Agency or Individual	Licensed Clinical Professional Counselor in the State of Montana		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
Agency or Individual	Licensed Clinical Psychologist in the State of Montana		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
Agency or Individual	Licensed Clinical Social Worker in the State of Montana		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.

**Verification of Provider Qualifications** (For each provider type listed above. Copy rows as needed):

Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Agency	MMIS Contractor, Montana Department of Public Health and Human Services.	Upon Enrollment; licensed mental health professionals are verified annually.

**Service Delivery Method.** (Check each that applies):

<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed
--------------------------	----------------------	-------------------------------------	------------------



**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title: **High Fidelity Wraparound Facilitation**

Service Definition (Scope):

High Fidelity Wraparound Facilitation Services are designed to support the family and youth in identifying, prioritizing and achieving their goals using the High Fidelity Wraparound process within a team of the family’s choosing. The high fidelity model includes training on specific skill sets, ongoing coaching to the skill sets and credentialing of facilitators and coaches who demonstrate their ability to deliver wraparound using this model. This approach standardizes the practice of wraparound facilitation and improves fidelity to the skill sets. Tasks may include but are not limited to: developing a Strengths, Needs and Cultural Discovery; assisting in identifying resources and making necessary referrals; developing and updating Functional Assessments and Crisis Plans; orienting members of the family team to the High Fidelity Wraparound process and their roles on the team; scheduling and facilitating family team meetings to validate and verify identified needs related to services in the Service Plan; maintaining communication among all team members; and providing documentation to the Regional Managers for Service Plan revisions. Every youth enrolled in the 1915(i) plan will receive High Fidelity Wraparound Facilitation services.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*

■ **Categorically needy *(specify limits):***

The High Fidelity Wraparound Facilitator and In-Home Therapist cannot be employed by the same agency.

A licensed mental health professional may be a High Fidelity Wraparound Facilitator if the provider qualifications are met. When the licensed mental health professional is the High Fidelity Wraparound Facilitator, the licensed mental health professional may not provide In-Home Therapy or other mental health therapy for the youth.

State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.

■ **Medically needy *(specify limits):***

The High Fidelity Wraparound Facilitator and In-Home Therapist cannot be employed by the same agency.

A licensed mental health professional may be a High Fidelity Wraparound Facilitator if the provider qualifications are met. When the licensed mental health professional is the High Fidelity Wraparound Facilitator, the licensed mental health professional may not provide In-Home Therapy or other mental health therapy for the youth.

State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.

**Provider Qualifications** *(For each type of provider. Copy rows as needed):*

Provider Type <i>(Specify):</i>	License <i>(Specify):</i>	Certification <i>(Specify):</i>	Other Standard <i>(Specify):</i>
Agency		All wraparound facilitators will be certified or working towards certification.	All wraparound facilitators will have attended high fidelity wraparound facilitation training sanctioned by the Department; are certified or working towards certification; and are receiving coaching through a coach certified by the Department.  Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
Agency or Individual	Licensed Clinical Professional Counselor in the State of Montana		All wraparound facilitators will have attended high fidelity wraparound facilitation training sanctioned by the Department; are certified or working towards certification; and are receiving coaching through a coach certified by the Department.  Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
Agency or Individual	Licensed Clinical Psychologist in the State of Montana		All wraparound facilitators will have attended high fidelity wraparound facilitation training sanctioned by the Department; are certified or working towards certification; and are receiving coaching through a coach certified by the Department.  Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
Agency or Individual	Licensed Clinical Social Worker in the State of Montana		All wraparound facilitators will have attended high fidelity wraparound facilitation training sanctioned by the Department; are certified or working towards certification; and are receiving coaching through a coach certified by the Department.  Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.

**Verification of Provider Qualifications** *(For each provider type listed above. Copy rows as needed):*

Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
Agency or Individual	MMIS Contractor, Montana Department of Public Health and Human Services.	Upon Enrollment; licensed mental health professionals are verified annually.

**Service Delivery Method.** *(Check each that applies):*

Participant-directed

Provider managed

**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title: **In-Home Therapy**

Service Definition (Scope):

In-Home Therapy is provided by a licensed mental health professional that provides face-to-face individual and family therapy for youth and families in the family home or community settings at times convenient for the family and youth. The In-Home Therapy duties may include but are not limited to assessing, developing and updating the treatment plan; communicating with the High Fidelity Wraparound Facilitator regarding status, services and treatment; guiding the family in the development of a crisis plan along with monitoring its implementation; and other treatment processes appropriate under the provision of the mental health professionals' license in the State of Montana. The individualized plan of care must identify a need for this service.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

Specify limits (if any) on the amount, duration, or scope of this service for *(choose each that applies)*:

Categorically needy *(specify limits)*:

The In-Home-Therapist and the High Fidelity Wraparound Facilitator cannot be employed by the same agency.

A licensed mental health professional may be a High Fidelity Wraparound Facilitator or Family Support Specialist if the provider qualifications are met. When the licensed mental health professional is the High Fidelity Wraparound Facilitator or Family Support Specialist, the licensed mental health professional may not provide In-Home Therapy or other mental health therapy for the youth.

State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.

Medically needy *(specify limits)*:

The In-Home Therapist and the High Fidelity Wraparound Facilitator cannot be employed by the same agency.

A licensed mental health professional may be a High Fidelity Wraparound Facilitator or Family Support Specialist if the provider qualifications are met. When the licensed mental health professional is the High Fidelity Wraparound Facilitator or Family Support Specialist, the licensed mental health professional may not provide In-Home Therapy or other mental health therapy for the youth.

State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.

**Provider Qualifications** *(For each type of provider. Copy rows as needed):*

Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Agency or Individual	Licensed Clinical Professional Counselor in the State of Montana		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
Agency or Individual	Licensed Clinical Psychologist in the State of Montana		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
Agency or Individual	Licensed Clinical Social Worker in the State of Montana		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.

**Verification of Provider Qualifications** (For each provider type listed above. Copy rows as needed):

Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Agency or Individual	MMIS Contractor, Montana Department of Public Health and Human Services.	Upon Enrollment and annually thereafter.

**Service Delivery Method.** (Check each that applies):

<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
---	--

**Service Specifications** (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):

Service Title:	Non-Medical Transportation
Service Definition (Scope):	
<p>Non-Medical Transportation is the provision of transportation through common carrier or private vehicle for the youth's access to and from social or other non-medical activities that are included in the plan of care. Non-Medical Transportation services are provided only after volunteer transportation services or other transportation services funded by other programs have been exhausted. Non-Medical Transportation services must be provided by the most appropriate cost effective mode. The individualized plan of care must identify a need for this service.</p>	
Additional needs-based criteria for receiving the service, if applicable (specify):	
Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):	
<input checked="" type="checkbox"/>	Categorically needy (specify limits): TN 13-036 Effective: 7/1/13      Approved: 09/20/13      Supersedes: TN 12-026

There is a limit of 400 miles of non-medical transportation per youth per enrollment year. State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.

■ **Medically needy (specify limits):**  
 There is a limit of 400 miles of non-medical transportation per youth per enrollment year. State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.

**Provider Qualifications** (For each type of provider. Copy rows as needed):

Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Agency with fiduciary and managerial capacity	Valid Montana driver's license;		Adequate automobile insurance; assurances that the vehicle is in compliance with all applicable federal, state and local laws and regulations. Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.

**Verification of Provider Qualifications** (For each provider type listed above. Copy rows as needed):

Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Agency with fiduciary and managerial capacity	MMIS Contractor, Department of Public Health and Human Services.	Upon Enrollment.

**Service Delivery Method.** (Check each that applies):

Participant-directed  Provider managed

**Service Specifications** (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):

Service Title: **Peer to Peer Services**

**Service Definition (Scope):**

Peer to Peer services are designed to offer and promote support to the parent/guardian of the youth with serious emotional disturbance AND/OR to the enrolled youth. Peer to Peer services promote self-efficacy of the parent/youth, enhance community living skills and develop natural supports. These services help the parent/guardian/youth access formal and informal supports. Peer-to-Peer Services support development, reconnection and strengthening of natural supports for families/youth; encourage development of Family to Family/Youth to Youth supports; play a vital role in helping a parent/caregiver/youth develop and practice skills and gain confidence in their abilities to manage crises and navigate service and other systems they are involved with. The individualized plan of care must identify a need for this service.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service for (*choose each that applies*):

- Categorically needy (*specify limits*):  
 State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.
- Medically needy (*specify limits*):  
 State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.

**Provider Qualifications** (*For each type of provider. Copy rows as needed*):

Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
Agency		Peer must attend training sanctioned by the Department; must be either certified or working towards certification.	Agency must have the capacity to provide Peer to Peer services with designated staff. Staff must receive appropriate supervision and coaching. Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.

**Verification of Provider Qualifications** (*For each provider type listed above. Copy rows as needed*):

Provider Type ( <i>Specify</i> ):	Entity Responsible for Verification ( <i>Specify</i> ):	Frequency of Verification ( <i>Specify</i> ):
Agency	MMIS Contractor, Department of Public Health & Human Services).	Upon enrollment.

**Service Delivery Method.** (*Check each that applies*):

- Participant-directed
  Provider managed

**Service Specifications** (*Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover*):

Service Title: Respite Services

Service Definition (Scope):  
 Respite services are temporary services provided to enrolled youth unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care to the enrolled youth. Respite services may be provided in time increments (15 minute units) or overnight (24 hour unit), depending on the needs of the youth and family. The individualized plan of care must identify a need for this service and the number/types of units necessary. The wraparound process includes encouraging families to establish and access natural supports that can also meet this need, limiting the dependence on paid respite services. The Regional Manager monitors as well as approves the prior authorization request to access respite, thus ensuring paid respite is only utilized on a temporary and/or intermittent basis.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service for (*chose each that applies*):

Categorically needy (*specify limits*):  
 State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. Generally, overnight respite should not exceed 7 consecutive days. Respite Services cannot be used or billed at the same time as Crisis Intervention Services.

Medically needy (*specify limits*):  
 State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. Generally, overnight respite should not exceed 7 consecutive days. Respite Services cannot be used or billed at the same time as Crisis Intervention Services.

**Provider Qualifications** (*For each type of provider. Copy rows as needed*):

Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
Agency	Therapeutic Group Home, Group Home or Youth Shelter Care		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
Agency			Provider with fiduciary and managerial capacity. Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
Agency	Mental Health Center		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.

**Verification of Provider Qualifications** (*For each provider type listed above. Copy rows as needed*):

Provider Type ( <i>Specify</i> ):	Entity Responsible for Verification ( <i>Specify</i> ):	Frequency of Verification ( <i>Specify</i> ):
Agency	MMIS Contractor, Department of Public Health & Human Services.	Upon enrollment.

**Service Delivery Method.** (*Check each that applies*):

<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
---	--

**Service Specifications** (*Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover*):

Service Title:	Specialized Evaluation Services
Service Definition (Scope):	

Specialized Evaluation Services are for youth enrolled in the 1915(i) HCBS state plan program. The Specialized Evaluation Services may include but are not limited to: Applied Behavior Analysis (ABA) and consultation, psychosexual evaluation and consultation, and pharmacogenetic evaluation.

Only those evaluations not covered by state plan Medicaid will be included in this 1915(i) service (e.g. regarding pharmacogenetic evaluation: the HCPCS code associated with the service reimburses an excessively low amount that the provider does not participate in state plan Medicaid for this service). There is a cap of \$1500 per enrollment year per youth for Specialized Evaluation Services. The individualized plan of care must identify a need for this service.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service for (*chose each that applies*):

- Categorically needy (*specify limits*):

State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.
- Medically needy (*specify limits*):

State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.

**Provider Qualifications** (*For each type of provider. Copy rows as needed*):

Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
Agency or Individual	Licensed Clinical Professional Counselor in the State of Montana with qualification to provide defined service.		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
Agency or Individual	Licensed Clinical Psychologist in the State of Montana with qualification to provide defined service.		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
Agency or Individual	Licensed Clinical Social Worker in the State of Montana with qualification to provide defined service.		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
Agency		Applied Behavior Analysis	Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
TN:13-036	Effective: 7/1/13	Approved:9/20/13	Supersedes: TN12-026



State: MONTANA			3.1-I Supplement to Attachment §1915(i) HCBS State Plan Services for High Needs Youth with SED Page 25
Agency	Laboratory	Specialized pharmacogenetic testing	Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
<b>Verification of Provider Qualifications</b> (For each provider type listed above. Copy rows as needed):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):		Frequency of Verification (Specify):
Individual or Agency	MMIS Contractor, Department of Public Health and Human Services.		Upon enrollment
<b>Service Delivery Method.</b> (Check each that applies):			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

<b>Service Specifications</b> (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):	
Service Title:	Crisis Intervention Service
Service Definition (Scope):	
<p>Crisis Intervention Service includes a short-term (not greater than 14 days) placement in a therapeutic group home or youth shelter home when intervention and short-term placement are necessary to avoid escalation and acute care admission. If there is indication a higher level of service is necessary, appropriate referrals will be made for the youth. Crisis Intervention Service allows families who are worn down and unable to continue coping an opportunity for their youth to receive this service while continuing to be involved with their youth. There is an overt understanding memorialized by a signed contract between all parties that the youth will be returning to the family home. The provider will work intensively with the youth and family to assess the situation that led to the crisis and to help the youth and family develop tools for the youth's successful return home, based on the youth's and family's strengths, needs and interaction patterns. Crisis Intervention Service is not routine respite services (respite services are planned, temporary services provided to enrolled youth unable to care for themselves that are furnished on a short-term, temporary basis because of the absence or need for relief of those persons who normally provide care to the enrolled youth). The individualized plan of care must identify a need for this service.</p> <p>Crisis Intervention Service is different than a regular therapeutic group home placement or youth shelter care home placement for the following reasons:</p> <ol style="list-style-type: none"> <li>1. Crisis Intervention Service is a 1915(i) HCBS service and therefore, the Team identified by the youth and family remains involved in the youth's and family's lives.</li> <li>2. Engagement of the immediate family is crucial to the youth's ability to return to the home setting.</li> <li>3. The length of stay is not greater than 14 days per episode (no consecutive stays for this service are allowed).</li> <li>4. The number of episodes of Crisis Intervention Service is not limited per enrollment year. However, youth who exceed three crisis episodes with subsequent Crisis Intervention Services per enrollment year will be re-evaluated to determine if the youth's health and safety needs can safely be met with 1915(i) HCBS State Plan program.</li> </ol> <p>Crisis Intervention Services are temporary and short term; utilized to assist youth and families in</p>	
TN 13-036 Effective: 7/1/13	Approved: 09/20/13
	Supersedes: TN 12-026

stabilizing a crisis. The wraparound team continues to meet to develop a detailed plan for the youth to return home. The Regional Managers must authorize requests for Crisis Intervention Services. The wraparound team ensures the plan of care has appropriate supports in place to manage the youth at home.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service for (*chose each that applies*):

- Categorically needy (*specify limits*):**  
 State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. Room and Board is not included in this service. Crisis Intervention Services cannot be used or billed at the same time as Respite Services.
- Medically needy (*specify limits*):**  
 State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. Room and Board is not included in this service. Crisis Intervention Services cannot be used or billed at the same time as Respite Services.

**Provider Qualifications** (*For each type of provider. Copy rows as needed*):

Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
Agency	Therapeutic Group Home		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
Agency	Youth Shelter Home		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.

**Verification of Provider Qualifications** (*For each provider type listed above. Copy rows as needed*):

Provider Type ( <i>Specify</i> ):	Entity Responsible for Verification ( <i>Specify</i> ):	Frequency of Verification ( <i>Specify</i> ):
Therapeutic Group Home	MMIS Contractor, Department of Public Health and Human Services.	Upon enrollment.
Youth Shelter Home	MMIS Contractor, Department of Public Health and Human Services.	Upon enrollment.

**Service Delivery Method.** (*Check each that applies*):

- Participant-directed
  Provider managed

**Service Specifications** (*Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover*):

Service Title: Co-Occurring Services

Service Definition (Scope):  
 Co-Occurring Services are designed to provide assessment/evaluation, education and treatment for Co-occurring mental health and chemical dependency issues for youth through an integrated approach. Co-occurring education and consultation for the youth's family are included in this service category. Co-Occurring Services are intended to improve or maintain current levels of functioning

and to reduce further exacerbation of the youth’s mental health and chemical dependency issues. Co-Occurring Services will be provided by a Licensed Addiction Counselor in conjunction with a Licensed Mental health Professional or a dually licensed professional. This process represents a coordinated approach to providing services to the youth/family. The individualized plan of care must identify a need for this service.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service for (*chose each that applies*):

- Categorically needy (*specify limits*):  
 State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.
- Medically needy (*specify limits*):  
 State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities.

**Provider Qualifications** (*For each type of provider. Copy rows as needed*):

Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
Agency or Individual	Licensed Clinical Professional Counselor in the State of Montana; with or without license as an Addiction Counselor		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services.
Agency or Individual	Licensed Clinical Psychologist in the State of Montana; with or without license as an Addiction Counselor		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services
Agency or Individual	Licensed Clinical Social Worker in the State of Montana; with or without license as an		Enrolled as a Montana Medicaid provider of 1915 (i) HCBS State Plan Services
TN:13-036	Effective: 7/1/13	Approved: 9/20/13	Supersedes: TN 12-026

State: MONTANA	Addiction Counselor		Supplement to Attachment 3.1-I §1915(i) HCBS State Plan Services for High Needs Youth with SED Page 28
Agency or Individual	Licensed Addiction Counselor in the State of Montana		Enrolled as a Montana Medicaid provider of 1915(i) HCBS State Plan Services
<b>Verification of Provider Qualifications</b> (For each provider type listed above. Copy rows as needed):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):	
Agency or Individual	MMIS Contractor, Department of Public Health and Human Services.	Upon Enrollment and annually thereafter.	
<b>Service Delivery Method.</b> (Check each that applies):			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

2.  **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** (By checking this box the State assures that): There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. (Specify (a) who may be paid to provide State plan HCBS ; (b) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):

The State will not make payments to legally responsible individuals, relatives or legal guardians for any of the 1915(i) HCBS State Plan services. Only qualified providers enrolled in Montana MMIS are eligible to render services to youth enrolled in the 1915(i) HCBS State Plan program.

## Participant-Direction of Services

*Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).*

**1. Election of Participant-Direction.** *(Select one):*

<input checked="" type="radio"/>	The State does not offer opportunity for participant-direction of State plan HCBS.
<input type="radio"/>	Every participant in State plan HCBS (or the participant’s representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	Participants in State plan HCBS (or the participant’s representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. <i>(Specify criteria):</i>

**2. Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

**3. Limited Implementation of Participant-Direction.** *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness requirements. Select one):*

<input type="radio"/>	Participant direction is available in all geographic areas in which State plan HCBS are available.
<input type="radio"/>	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit’s standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. <i>(Specify the areas of the State affected by this option):</i>

**4. Participant-Directed Services.** *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

**5. Financial Management.** *(Select one):*

<input checked="" type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="radio"/>	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6.  **Participant-Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual’s ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

7. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the State facilitates an individual’s transition from participant-direction, and specify any circumstances when transition is involuntary):*

--

8. **Opportunities for Participant-Direction**

a. **Participant-Employer Authority** (individual can hire and supervise staff). *(Select one):*

<input checked="" type="radio"/>	The State does not offer opportunity for participant-employer authority.
<input type="radio"/>	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
<input type="checkbox"/>	<b>Participant/Co-Employer.</b> The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
<input type="checkbox"/>	<b>Participant/Common Law Employer.</b> The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

**b. Participant–Budget Authority** (individual directs a budget). *(Select one):*

<input checked="" type="radio"/>	The State does not offer opportunity for participants to direct a budget.
<input type="radio"/>	Participants may elect Participant–Budget Authority.
	<b>Participant-Directed Budget.</b> <i>(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):</i>
	<b>Expenditure Safeguards.</b> <i>(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):</i>

State: MONTANA

Supplement to Attachment 3.1A/B  
§1915(i) HCBS State Plan Services for High Needs Youth with SED







§1915(i) HCBS State Plan Services for High Needs Youth with SED

State: MONTANA

<p>2. Enrolled youth will reside in a family home or licensed foster home.</p>	<p>The Plan of Care must document where the enrolled youth is residing.</p>	<p>All Plans of Care will be reviewed by the SMA (directly by staff or indirectly through contracted positions) with copies of the plans of care on file by the SMA.</p>	<p>freedom of choice of providers) initially and at least every 12 months thereafter.</p>	<p>Initial plan of care and at least every 12 months thereafter.</p>	<p>SMA                  If a corrective action plan is needed, it must be provided within 15 working days and the SMA will respond in 15 working days for a total of 30 working days.</p>	<p>All plans of care upon initial enrollment and at least every 12 months thereafter.</p>
<p>3. The UR Contractor (in the absence of the UR Contractor, the Regional Manager) completes the Needs-Based eligibility criteria and face-to-face</p>	<p>The UR Contractor (in the absence of the UR Contractor, the Regional Manager) will document adherence to the Needs-Based eligibility criteria and will document the findings of the face-to-</p>	<p>The UR Contractor (in the absence of the UR Contractor, the Regional Manager) will keep details reports outlining the date of referral; the date and outcome of the Needs-Based eligibility criteria completion; the</p>	<p>SMA; an employee in the Children's Mental Health Bureau within the Department is given the</p>	<p>Monthly</p>	<p>SMA; in accordance with contract language regarding any corrective action plan</p>	<p>Monthly</p>

Approved: 09/20/13

Effective: 7/1/13

TN 13-036

Supersedes: TN 12-026

§1915(i) HCBS State Plan Services

State: MONTANA

<p>assessments</p>	<p>face assessments.</p>	<p>date and outcome of the face-to-face assessments.</p>	<p>responsibility for UR Contractor oversight. The UR Contractor will submit routine reports outlining all activities relevant to the 1915(i) HCBS State Plan program. In the absence of the UR contractor, the Regional Manager will keep detailed reports outlining all activities relevant to the 1915(i) HCBS spa.</p>	<p>Initial enrollment; annually for licensed providers.</p>
<p>4. Providers meet required qualifications.</p>	<p>All providers of 1915(i) HCBS state plan services must have a current provider agreement on file with the SMA's fiscal intermediary Contractor</p>	<p>Verify that 100% of providers for 1915(i) HCBS state plan services have provider agreements on file with the fiscal intermediary. SMA will provide provider qualifications to the fiscal intermediary outlining the enrollment process for 1915(i) HCBS state plan providers.</p>	<p>SMA</p> <p>If a corrective action plan is needed, it must be provided within 15 working days and the SMA will respond in 15 working days for a total of 30 working days.</p>	<p>Initial enrollment; annually for licensed providers.</p>
<p>5. The SMA retains authority and</p>	<p>SMA oversight occurs through the reviews of the plans of care for</p>	<p>Individual plans of care for youth enrolled in the 1915(i) HCBS state</p>	<p>SMA</p>	<p>On-going review of initial plans of care and any subsequent</p>

09/20/13

Approved:

Effective: 7/1/13

Supersedes: TN 12-026

TN: 13-036

<p>responsibility for program operations and oversight.</p>	<p>enrollees (by staff or through contracted positions). These reviews will ensure providers adhere to federal and state program requirements policies and regulations for the 1915(i) program.</p>	<p>plan;</p>		<p>concern or complaint received.</p>	<p>If a corrective action plan is needed, it must be provided within 15 working days and the SMA will respond in 15 working days for a total of 30 working days.</p>	<p>reviews of amended plans of care.</p>
<p>6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.</p>	<p>SMA oversight through the MMIS system to ensure claims for 1915(i) HCBS state plan enrollees are being paid to providers of 1915(i) HCBS state plan services in accordance with the state plan and the youth's individual plan of care.</p>	<p>MMIS paid claims reports; individual plans of care for youth enrolled in the 1915(i) HCBS state plan;</p>	<p>SMA</p>	<p>On-going and upon receipt of any concern or complaint received.</p>	<p>SMA  If a corrective action plan is needed, it must be provided within 15 working days and the SMA will respond in 15 working days for a total of 30 working days.</p>	<p>On-going review of MMIS paid claims reports;</p>
<p>7. The State identifies, addresses and seeks to prevent incidents of</p>	<p>All plans of care for youth enrolled in the 1915(i) HCBS state plan must have a completed safety/crisis plan on file addressing the health,</p>	<p>Verify safety/crisis plans are in the youth's service file. Review any serious occurrence reports in the youth's</p>	<p>SMA</p>	<p>Ongoing and upon receipt of any concern or complaint</p>	<p>SMA  If a corrective action plan is</p>	<p>On-going review of initial plans of care and ensure there is a safety/crisis plan also on file.</p>

TN 13-036      Effective: 7/1/13      Approved: 09/20/13      Supersedes: TN 12-026

<p>abuse, neglect, and exploitation, including the use of restraints.</p>	<p>safety and welfare of the youth. This is in accordance with the provision of services using the high fidelity wraparound philosophy. In addition, the providers of 1915(i) HCBS state plan services will be made aware of their responsibilities to report and suspected abuse, neglect and exploitation to Child and Family Services hot line. The provider policy manual will include this responsibility as these providers, the SMA staff and any contracted positions are mandatory reporters regarding suspected abuse, neglect and exploitation.</p>	<p>file.</p>		<p>received.</p>	<p>needed, it must be provided within 15 working days and the SMA will respond in 15 working days for a total of 30 working days.</p>
---	--	--------------	--	------------------	---

**System Improvement:**

*(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*

<p>8. Methods for Analyzing Data and Prioritizing Need for System</p>	<p>Roles and Responsibilities</p>	<p>Frequency</p>	<p>Method for Evaluating Effectiveness of System Changes</p>
<p>TN 13-036</p>	<p>Effective: 7/1/13</p>	<p>Approved: 09/20/13</p>	<p>Supersedes: TN 12-026</p>

<p>Improvement</p>			
<p>9. We will be collecting data on each youth enrolled in the 1915(i) HCBS state plan using the Child and Adolescent Needs and Strengths (CANS) functional assessment tool. The CANS will be administered by the high fidelity wraparound facilitators. The data will be stored in a data warehouse that is accessible to the SMA. The data will provide us information on the youth enrolled in the 1915(i) HCBS state plan upon initial enrollment and periodically throughout the youth's enrollment. Concurrently, we will be monitoring usage of other youth mental health services reimbursed by Montana Medicaid and compare this data to pre-1915(i) HCBS state plan implementation. We expect to see decreases in some of the higher cost youth mental health services.</p>	<p>SMA</p>	<p>CANS will be administered at enrollment, every 3 months from the last CANS assessment date and upon discharge. CANS may be administered more frequently as determined by the wraparound facilitator and Team. Children's Mental Health Bureau within the Department is exploring options for a data warehouse relevant to CANS data. The requirements are being developed including quarterly report generation, trending, and all practice and</p>	<p>Data will be gathered for youth who are enrolled in the 1915(i) HCBS state plan and compared to previous paid claims information regarding service utilization. The data may indicate a need to collect information for all youth served by mental health providers using the CANS functional assessment tool.</p>
<p>TN 13-036</p>	<p>Effective: 7/1/13</p>	<p>Approved: 09/20/13</p>	<p>Supersedes: TN 12-026</p>

§1915(i) HCBS State Plan Services for High Needs Youth with SED

program uses for the  
CANS data. The  
information  
generated from the  
reports, including  
trending, will be  
shared with the  
1915(i) HCBS  
Quality Assurance  
Committee that  
meets quarterly.

Supersedes: TN 12-026

State: MONTANA

09/20/13

Approved:

Effective: 7/1/13

TN 13-036

## Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

<input checked="" type="checkbox"/>	<p>HCBS Case Management (CASE MANAGEMENT FUNCTIONS ARE PROVIDED BY <b>High Fidelity Wraparound Facilitators</b>; SEE BELOW)</p>
<input type="checkbox"/>	<p>HCBS Homemaker</p>
<input type="checkbox"/>	<p>HCBS Home Health Aide</p>
<input type="checkbox"/>	<p>HCBS Personal Care</p>
<input type="checkbox"/>	<p>HCBS Adult Day Health</p>
<input type="checkbox"/>	<p>HCBS Habilitation</p>
<input checked="" type="checkbox"/>	<p>HCBS Respite Care</p> <p>The agency's rates effective July 1, 2013 for services on or after that date are published on the agency's website at <a href="http://www.mtmedicaid.org">www.mtmedicaid.org</a>. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.</p> <p><u>Respite Services</u> rates were originally established on January 1, 2013. The 15 minute unit was based on other waiver respite reimbursement. The 24 hour overnight rate was set at an amount less than the daily rate for a psychiatric residential treatment facility yet sufficient for provider participation. On July 1, 2013 the 15 minute unit respite service rate will be increased by 2%. The 24 hour overnight rate is not being increased.</p>
<input checked="" type="checkbox"/>	<p>HCBS Consultative Clinical and Therapeutic Services</p> <p>The agency's rates effective July 1, 2013 for services on or after that date are published on the agency's website at <a href="http://www.mtmedicaid.org">www.mtmedicaid.org</a>. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.</p> <p><u>Consultative Clinical and Therapeutic Services</u> rate was established January 1, 2013 using RBRVS methodology (rate methodology for physician, mid-level practitioner and psychiatrist) as the basis for computation of the rate, with adjustments.</p>
<input checked="" type="checkbox"/>	<p>HCBS Supplemental Supportive Services</p> <p>The agency's rates effective July 1, 2013 for services on or after that date are published on the agency's website at <a href="http://www.mtmedicaid.org">www.mtmedicaid.org</a>. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both</p>
<p>TN 13-036 Effective: 7/1/13 Approved: Supersedes: TN 12-026</p>	



governmental and private providers.  
Supplemental Supportive Services have an upper limit, must be adequately described and included within the plan of care, and require prior authorization.

■ HCBS Education and Support Services

The agency's rates effective July 1, 2013 for services on or after that date are published on the agency's website at [www.mtmedicaid.org](http://www.mtmedicaid.org). Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.  
Education and Support Services have an upper limit, must be adequately described and included within the plan of care, and require prior authorization.

■ HCBS Family Support Specialist

The agency's rates effective-July 1, 2013 for services on or after that date are published on the agency's website at [www.mtmedicaid.org](http://www.mtmedicaid.org). Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

The Family Support Specialist may be eligible for a geographical factor when the provider is traveling out of the location where this provider has its regular office, excluding satellite offices; the provider is traveling a distance of 25 miles or more one way from the office to the youth's home; the geographical factor will include the initial 25 miles and return trip; the geographical factor is included in the youth's individualized plan of care.

**Rates were established January 1, 2013 using the following calculation:**

Total Estimated Cost (salary, benefits, direct supervision, indirect costs, mileage) per FTE Per Year ÷ Billable Hours Per Year (÷ 4 = 15 Minute Units) = Baseline Rate x Policy Adjustor = 1915i HCBS Rate. On July 1, 2013 this rate will be increased by 2%.

■ HCBS High Fidelity Wraparound Facilitator

The agency's rates effective-July 1, 2013 for services on or after that date are published on the agency's website at [www.mtmedicaid.org](http://www.mtmedicaid.org). Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

The High Fidelity Wraparound Facilitator may be eligible for a geographical factor when the provider is traveling out of the location where this provider has its regular office, excluding satellite offices; the provider is traveling a distance of 25 miles or more one way from the office to the youth's home; the geographical factor will include the initial 25 miles and return trip; the geographical factor is included in the youth's individualized plan of care.

**Rates were established January 1, 2013 using the following calculation:**

Total Estimated Cost (salary, benefits, direct supervision, indirect costs, mileage) per

	FTE Per Year ÷ Billable Hours Per Year (÷ 4 = 15 Minute Units) = Baseline Rate x Policy Adjustor = 1915i HCBS Rate. On July 1, 2013 this rate will be increased by 2%.
■	HCBS In-Home Therapy
	<p>The agency's rates effective-July 1, 2013 for services on or after that date are published on the agency's website at <a href="http://www.mtmedicaid.org">www.mtmedicaid.org</a>. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.</p> <p>The In-Home Therapist may be eligible for a geographical factor when the provider is traveling out of the location where this provider has its regular office, excluding satellite offices; the provider is traveling a distance of 25 miles or more one way from the office to the youth's home; the geographical factor will include the initial 25 miles and return trip; the geographical factor is included in the youth's individualized plan of care.</p> <p><b><u>Rates were established January 1, 2013 using the following calculation:</u></b> Total Estimated Cost (salary, benefits, direct supervision, indirect costs, mileage) per FTE ÷ Billable Encounters Per Year = Baseline Rate x Policy Adjustor = 1915i HCBS Rate. On July 1, 2013 this rate will be increased by 2%.</p>
■	HCBS Non-Medical Transportation
	<p>The agency's rates effective-July 1, 2013 for services on or after that date published on the agency's website at <a href="http://www.mtmedicaid.org">www.mtmedicaid.org</a>. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.</p> <p><u>Non-Medical Transportation Services</u> has the same rate as the state plan transportation reimbursement rate.</p>
■	HCBS Peer-to-Peer Services
	<p>The agency's rates effective-July 1, 2013 for services on or after that date are published on the agency's website at <a href="http://www.mtmedicaid.org">www.mtmedicaid.org</a>. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.</p> <p>The Peer-to-Peer may be eligible for a geographical factor when the provider is traveling out of the location where this provider has its regular office, excluding satellite offices; the provider is traveling a distance of 25 miles or more one way from the office to the youth's home; the geographical factor will include the initial 25 miles and return trip; the geographical factor is included in the youth's individualized plan of care.</p> <p><b><u>Rates were established January 1, 2013 using the following calculation:</u></b> Total Estimated Cost (salary, benefits, direct supervision, indirect costs, mileage) per FTE Per Year ÷ Billable Hours Per Year (÷ 4 = 15 Minute Units) = Baseline Rate x Policy Adjustor = 1915i HCBS Rate. On July 1, 2013 this rate will be increased by 2%.</p>
TN 13-036 Effective: 7/1/13 Approved: 12/21/12 Supersedes: TN 12-026	

State: MONTANA		§1915(i) HCBS State Plan Services for High Needs Youth with SED	
		Attachment 4.19-B: Page 4	
<input checked="" type="checkbox"/>	HCBS Specialized Evaluation Services	The agency's rates effective-July 1, 2013 for services on or after that date are published on the agency's website at <a href="http://www.mtmedicaid.org">www.mtmedicaid.org</a> . Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers. <u>Specialized Evaluation Services</u> have an upper limit, must be adequately described and included within the plan of care, and require prior authorization.	
<input checked="" type="checkbox"/>	HCBS Co-Occurring Service	The agency's rates effective-July 1, 2013 for services on or after that date are published on the agency's website at <a href="http://www.mtmedicaid.org">www.mtmedicaid.org</a> . Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers. Co-Occurring providers may be eligible for a geographical factor when the provider is traveling out of the location where this provider has its regular office, excluding satellite offices; the provider is traveling a distance of 25 miles or more one way from the office to the youth's home; the geographical factor will include the initial 25 miles and return trip; the geographical factor is included in the youth's individualized plan of care. <b><u>Rates were established January 1, 2013 using the following calculation:</u></b> Total Estimated Cost (salary, benefits, direct supervision, indirect costs, mileage) per FTE ÷ Billable Encounters Per Year = Baseline Rate x Policy Adjustor = 1915i HCBS Rate. On July 1, 2013 this rate will be increased by 2%.	
<input checked="" type="checkbox"/>	Crisis Intervention Services	The agency's rates effective-July 1, 2013 for services on or after that date are published on the agency's website at <a href="http://www.mtmedicaid.org">www.mtmedicaid.org</a> . Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers. <u>Crisis Intervention Services</u> will use the 24 hour unit rate of reimbursement for Respite Services as the providers are likely to be the same.	
<input type="checkbox"/>	HCBS		
For Individuals with Chronic Mental Illness, the following services:			
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services		
<input type="checkbox"/>	HCBS Psychosocial Rehabilitation		
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)		
TN 13-036 Effective: 7/1/13 Approved:		Supersedes: TN 12-026	